Recommendations for a National Strategy on Aboriginal **AIDS** Education and Prevention

Health and Welfare Canada
Santé et Bien-être social Canada
Canada

Recommendations For

A

NATIONAL STRATEGY ON

ABORIGINAL AIDS EDUCATION AND PREVENTION

Joint National Committee on Aboriginal
AIDS Education and Prevention

The committee was created in 1989 to research and report its findings to the Minister of National Health and Welfare Canada and make recommendations on the issue of AIDS as it affects aboriginal people in Canada.

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EXECUTIVE SUMMARY

1.0 INTRODUCTION

1.1 The **Joint National Committee on Aboriginal AIDS Education and Prevention**, officially announced on April 12, 1989 by the Minister of Health and Welfare Canada, the Honourable Perrin Beatty, is a partnership which includes representatives from the eleven national aboriginal organizations, Health and Welfare Canada and the Department of Indian and Northern Affairs.

1.2 The mandate of the Joint National Committee, (JNC) supported by both the aboriginal leadership and Health and Welfare Canada, was to develop a culturally-appropriate National Aboriginal AIDS Education and Prevention Strategy by December 15, 1989.

2.0 METHODOLOGY

2.1 The research and information gathering approach adopted by the JNC included; a Call For Papers: presentations by involved groups; a questionnaire on aboriginal specific initiatives; visits to projects; and, a literature and document review.

2.2 Three documents emerged from this process; The Interim Report, June 26, 1989; The Findings Document and the Recommendations for a National Strategy Document, December 14, 1989.

3.0 **PURPOSE**

3.1 The purpose of the Strategy is to guide aboriginal governments, the Federal Centre for AIDS and others who may become involved, in determining the most effective measures to take in the battle against AIDS in aboriginal communities.

4.0 **RATIONALE**

4.1 The research clearly indicated that due to the cultural, social, political, geographic and language differences between the aboriginal population and mainstream Canadian society, special measures and a unique strategy are required to meet the needs of aboriginal people in AIDS education and prevention efforts.

In addition, the research indicates that the potential for aboriginal communities following the course of Pattern II countries (heterosexual transmission of HIV) in developing AIDS, is great. As a result, a broader more complex approach to education and prevention is required.

5.0 GOALS OF THE STRATEGY

(1) To increase general awareness and knowledge about HIV transmission, infection and the development of HIV spectrum diseases and AIDS in the aboriginal population.

(2) To reduce the transmission of the (HIV) virus through education and prevention measures aimed at promoting responsible behaviour such as safer sex practices and safer injection drug practices.

(3) To encourage and support sustained behavior change through community understanding and action.

(4) To encourage individuals who may be at a greater risk of contracting the (HIV) virus to accept personal responsibility for changing unsafe practices.

(5) Assist aboriginal communities to help those who are HIV positive and are expressing HIV spectrum diseases and AIDS.

(6) Assist aboriginal communities in addressing the social and economic impacts of HIV spectrum diseases and AIDS.

6.0 GUIDING PRINCIPLES

6.1 In keeping with the four gifts of the Creator: kindness, honesty, sharing and strength, the Joint National Committee has developed the following guiding principles to assist in the development of aboriginal AIDS education and prevention programs and policies:

(1) The approach must be holistic and rooted in the culture, traditions and customs of aboriginal communities and therefore, must embrace the entire community including the youth, parents, elders and community leaders;

(2) The approach must be positive in nature rather than critical of past behaviors;

(3) The approach must support the empowerment of the community and individuals in their efforts to take responsibility;

(4) The approach must ensure equity of access for all individuals aboriginal and communities;

(5) The approach must be cognizant and sensitive to differing views of sexuality;

(6) The approach should promote the development of comprehensive efforts against AIDS by communities which includes education and prevention of HIV infection and builds tolerance and understanding of those already infected.

7.0 ELEMENTS OF THE STRATEGY

The National Strategy on Aboriginal AIDS Education and Prevention incorporates five elements to facilitate the attainment of the Goals.

(1) General awareness and education campaigns which are aboriginal - specific and culturally transportable for broad usage with the support of human and financial resources.

(2) Specific community-based education and prevention initiatives designed and delivered by local people with the support of appropriate human and financial resources.

(3) The establishment of AIDS education and prevention measures as priorities within all aboriginal decision-making forums. (For example: First Nations Government Meetings, School Board Meetings, Regional Board Meetings, Tribal activities etc.)

(4) Directed research which will assist in the development and/or evaluation of future education and prevention efforts and initiatives.

(5) Maintenance of the Joint National Committee with a new mandate for a period of three years to ensure that the strategy is marketed, effectively implemented and evaluated.

8.0 PROGRAM GUIDELINES

Aboriginal organizations and community groups have initiated a variety of AIDS education and prevention activities across Canada. As a part of the Joint National Committees research, those organizations and others were requested to share their ideas on what activities were most effective and had the potential for the greatest impact on aboriginal communities. As a result of their input and additional research, program guidelines have been developed which focus on the five elements of the strategy and the guiding principles on which the strategy is based.

9.0 GENERAL RECOMMENDATIONS

The JNC has put forward nineteen (19) recommendations for the consideration of the aboriginal leadership, the Federal Government and others involved in aboriginal AIDS education and prevention. The recommendations cover a range of areas including: financial support for community-based projects; recommended research activities; improvements in health care delivery; access to HIV testing and, support for an International Indigenous Peoples AIDS Conference, hosted by Canada.

10.0 ROLES AND RESPONSIBILITIES

The JNC has identified and described the roles and responsibilities of all parties involved in the issue of AIDS and the aboriginal population including; the individual, aboriginal communities, aboriginal governments, aboriginal organizations and institutions, the Federal Government and Provincial/ Territorial Governments.

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Joint National Committee

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Preface

Aids is a disease which affects each and every one of us. It is a disease which causes us to think about the fragility of life and to appreciate the gift which we have been given from our Creator. We are caused to think about our own mortality, our place within the cycle of nature and we are moved to put aside our differences and to take whatever action we can to preserve this gift for ourselves and for our children.

We began this journey in February, 1989 in a climate of uncertainty, not knowing what we would discover but feeling that if we were to produce a result which would be beneficial to our communities we should obtain the services of someone who shared our concerns and who could steer our diverse group through the choppy waters of this subject.

The Committee would like to thank Mary Jamieson, a Mohawk from the Six Nations Reserve, who laboured long and hard in order to make the work of the committee easier. Mary performed her duties in a truly remarkable manner over the short time we had to produce our report. We are proud of her efforts in gathering data, in helping us to understand it and for helping us to maintain a balanced perspective of a subject fraught with medical, social and sexual complexities.

We would also like to thank the Federal Centre for Aids for their generous support for the work of the committee, and Barbara Jones, Bob Imrie and Cathie Bruyere for their efforts in assisting the committee to complete its work within the agreed upon timeframe.

We would also like to thank our medical advisor, Dr. Jay Wortman, a Metis physician from Vancouver. Dr. Wortman served as an astute guide through the medical literature to help us understand the nature of the virus, its manner of expression in the human body and the current state of knowledge about its treatment.

We end this part of our journey in December, 1989 in a climate of hope, a hope that our work will help our communities to understand the nature of the threat which faces them and that our work will provide them with the tools to reduce this threat and to assist those who are living with this disease.

David R. Newhouse,
Chairman.

1.0 Introduction

1.1 The **Joint National Committee on Aboriginal AIDS Education and Prevention**, officially announced on April 12, 1989 by the Minister of Health and Welfare Canada, the Honourable Perrin Beatty, is a partnership which includes representatives from the eleven national aboriginal organizations, Health and Welfare Canada and the Department of Indian Affairs and Northern Development.

Members include:

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Aboriginal Youth Council of Canada (AYCC)

Ray Fox
National Aboriginal Communications Society (NACS)

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Robert Imrie
Federal Centre for AIDS, Health and Welfare Canada

Dr. Jay Wortman (Medical Advisor)
British Columbia Ministry of Health, Vancouver

Mary E. Jamieson (Co-ordinating Consultant)
Native Management Services

1.2 The mandate of the Joint National Committee, supported by both the aboriginal leadership and Health and Welfare Canada, was to develop a culturally appropriate National Aboriginal AIDS Education and Prevention Strategy by December 15, 1989.

1.3 As an initial step, the national aboriginal organizations made the decision to root the strategy in the values and beliefs of the aboriginal people and to this end have incorporated the four gifts of the Creator: kindness, honesty, sharing and strength into all aspects of the Strategy.

The gift of **KINDNESS** ensures that we respect and treat with dignity, all of the Great Spirit's creations including those people living with AIDS.

The gift of **HONESTY** ensures that we face the problem of AIDS with an awareness that it does affect our communities and that we take responsibility for our actions with sincerity and openness.

The gift of **SHARING** ensures that we provide others with clear, concise and factual information about AIDS and that we share our ideas and approaches with others.

The gift of **STRENGTH** ensures that we work collectively and with one mind to combat the serious threat presented to our people in the further spread of the disease.

1.4 METHODOLOGY

The research and information gathering strategy adopted by the Joint National Committee included the following five initiatives:

(1) A "Call for Papers" to solicit views from a variety of sources;

(2) Presentations by community AIDS and health organizations;

(3) A questionnaire to compile information on aboriginal-specific AIDS prevention activities and needs;

(4) Visits to aboriginal AIDS education and prevention projects;

(5) A comprehensive literature and document review based on a research framework.

Two documents resulted from this process. The first document, the Interim Report released on June 26, 1989, was made widely available to the aboriginal community, federal and provincial/ territorial levels of government and other interested organizations and groups across Canada. The constructive criticism and additional input the Committee received as a result of the Interim Report was considered in the second document, The Findings Document, which was completed in November, 1989.

The Findings Document identifies and addresses many issues relating to the aboriginal population and AIDS but specifically focuses on the two hypotheses developed by the Joint National Committee:

(1) The factors that lead to HIV infection and to the development of HIV spectrum diseases and AIDS are present within the aboriginal community;

(2) There is a need for aboriginal-specific AIDS education and prevention programs and activities.

The Findings Document represents a compilation of all research done from April to November, 1989 to guide the development of the National Strategy.

1.4 The Aboriginal Population - Characteristics that Impact The Aids Education and Prevention Strategy

1.4.1 OVERVIEW

According to the 1981 Canada Census, the total aboriginal population including Indian, Inuit and Metis is estimated at 491,450; but, in contrast,

aboriginal organizations have estimated the total population at 700,000*. The aboriginal population live on and off reserve, in remote, isolated and rural communities, and in large urban centres across Canada. There are fifty-three (53) aboriginal languages in existence with nine (9) languages being spoken as the first language of communication and an additional twenty-six (26) being spoken as second languages. Of the two "official languages", English is spoken by the majority (over 60%) of aboriginal people with French usage estimated at less than 10%.

1.4.2 **AGE/BIRTH RATE**:

Over forty percent (40%) of the aboriginal population is younger than 15 and two-thirds are younger than 25 compared to the total Canadian population where only one-third are younger than 15 years of age.

The fertility rate of Indians (one group within the aboriginal population) between the ages of 20 to 24 is twice the Canadian average.

Although the birth rate is declining, the rate remains high. James S. Frideres in, Native Peoples in Canada - Contemporary Conflicts, points out the following:

In 1981, Native women had an average of 3.8 children compared to 2.5 for non-Native women. When controlling for age, we find that the older Native women (65 and over) had 6.3 children (3.2 for non-Native); 6.1 children for Native women 45 - 64 (3.3 for non-Native women of this age).[1]

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*The variance in population estimates between the Canada Census and aboriginal organizations is largely due to the fact that many aboriginal people (30% or more) do not participate in the Canada Census.

Aboriginal women have larger families at a younger age than other Canadian women. Although a current reference for the rate of teenage pregnancies among the aboriginal population nationally is not available localized community-based studies indicate that the rate of teenage pregnancies (under 17) is twice that of surrounding non-aboriginal communities.

The aboriginal population is younger than the mainstream population and as the limited data on teenage pregnancies indicates, they are sexually active and more importantly, not engaging in safe sex practices. There is sufficient evidence, based on STD rates and high fertility rates, to indicate that the virus, once present, has the means to spread quickly through the aboriginal population.

1.4.3 SEXUAL ORIENTATION AND BEHAVIOUR

Accurate data is not available on the incidence of homosexuality or the prevalence of participation in homosexual behaviour within the aboriginal population. However, four aboriginal gay and lesbian organizations/groups have emerged across Canada.

Because there is a lack of documentation on the sexual behaviours and customs of the various aboriginal cultures it is difficult for the Joint National Committee to provide concrete recommendations or develop measures that would influence behaviours within these groups.

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[1]James S. Frideres, Native People in Canada - Contemporary Conflicts, Prentice-Hall Canada Inc., Scarborough, Ontario, 1988.

The aboriginal lesbian and gay organizations have begun to provide information and educate their communities about AIDS. The Committee believes that these groups should be supported and encouraged to continue their efforts to educate these high risk populations.

1.4.4 EDUCATION LEVELS & LITERACY LEVELS

Although the level of educational attainment is steadily improving, the rate of Indian and Inuit students completing grades 12 and 13 in 1988 is still less than one-quarter of the national rate. Although current literacy levels for the aboriginal population were not available from the National Literacy Project, Ottawa, based on grade level attainment alone, literacy levels in aboriginal communities appear to be lower than the national level. Therefore, printed literature on AIDS education and prevention will need to be supplemented by other audio-visual material to a greater extent than in mainstream populations.

1.4.5 GEOGRAPHIC LOCATION OF ABORIGINAL COMMUNITIES

As noted earlier, the Aboriginal population lives in rural, remote and isolated communities, on and off reserve and in urban centres across Canada.

According to Frideres:

About 70 percent of the Indian population on reserves are located in rural or remote locations; this can be compared to a national average of 25 percent. Rural bands refer to those more than 60 miles from the nearest urban centre, and remote bands are all those lacking roads for transportation to an urban centre. However, Indians have not remained as socially isolated from modern non-Indian society as this statistic would suggest. Nationally, fewer than 30 percent

live in remote locations. This figure varies by region, with a low of five percent in the Maritimes, 44 percent in Manitoba, and with a high of over 80 percent in Yukon.

The recent trend in the residential patterns of Canadian Indians indicate that an increasing number of them are moving to urban areas. Of these, over half are relocating in large metropolitan areas of more than 100,000 people. There are two explanations for the migration to large cities. First, unskilled employment is easier to obtain in large cities than in small towns. Second, Native ghettos are developing in various cities such as Winnipeg, Toronto, and Edmonton; once a sizable population of an ethnic group resides in a given poverty area, other members of that group find it easier to move there...[2]

Over ninety percent (90%) of the Inuit population lives in remote and northern parts of Canada, that is the NWT, northern Quebec and Labrador. These areas are isolated and hence difficult to access via the mainstream media.

Because aboriginal people live in a variety of settings and ready access to relevant information and services varies depending on location, effective Aboriginal AIDS education and prevention efforts should be community-based both in terms of design and delivery

1.4.6 HEALTH STATUS

The life span of aboriginal people is estimated at ten years less than the average Canadian and the infant mortality rate is forty percent (40%) higher than that of mainstream Canada.

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[2]Ibid., p. 154.

In Frideres' discussion on mortality rates, indicates the following:

> Poor health and high mortality rates on reserves are directly related to poor access to medical facilities, the lack of sewage disposal, the unchecked exposure to disease, and a general lack of health care services. The mortality rate for Indians in 1963 was extremely high, 25 per 1000. Although this had decreased to 15 per 1000 by 1981, it still remains much higher than the national rate of 7 per 1000. Infant mortality (up to four weeks) and post-neonatal mortality (four weeks to one year) have also been very high. In 1963, the post-neonatal mortality rate was 60 per 1000, compared to 9 per 1000 for the national population. By 1977, this rate had decreased substantially; however, at 15 per 1000, it still remained twice as high as the national rate. By 1983 the post-neonatal rate had decreased even further but it still remains about 3.8 times higher than the general population.[3]

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[3]Ibid., p. 199.

According to an article published by the Canadian Medical Association in November, 1985 by Shah and Farkas,

> Canadian Indians also have a high incidence of major causes of disability, such as anemia, diabetes, gallbladder disease, infectious and parasitic diseases, lung disease, hearing impairment, visual defects and dental problems. Mental health disorders and problems resulting from drug and alcohol abuse are also prevalent. The proportion of disabled and handicapped native people is higher than in any other segment of the Canadian population.[4]

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[4]Shah and Farkas, The Health of Indians in Canadian Cities: A Challenge to the Health Care System, Canadian Medical Association, Vol. 133, November 1, 1985.

In addition, as an example, Lee et al reported on an outbreak of infectious syphilis in Manitoba in 1984. "The case rate for native Indians was 21.7 per 100,000 population compared with 6.6 per 100,000 for the non-native population."[5]

It is clear that people with STDs have engaged in unsafe sex.

The high level of STDs within the aboriginal community indicates that the virus once present may be able to be transmitted more efficiently from individual to individual as a result of the presence of open genital sores caused by certain STDs.

Recent research (including that of the World Health Organization) indicates that an immune system that is compromised by other infections and diseases may provide for a more rapid expression of HIV spectrum diseases and AIDS once an individual is infected with the virus.

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[5]Health and Welfare Canada, Health Status of Canadian Indians and Inuit: Update 1987, MSB, Ottawa, 1988.

1.4.7 THE ABORIGINAL POPULATION/CULTURALLY HETEROGENEOUS

The aboriginal population of Canada is comprised of a wide variety of cultural groups; speaking different languages, living in a variety of locations, practicing different traditions, customs and lifestyles. Because of the diversity, views of what is acceptable in terms of behaviour and what is effective in stimulating and sustaining change in behaviour varies within the aboriginal population.

Therefore, the development of a "generic" Aboriginal AIDS Education and Prevention message would be impossible and ineffective.

1.4.8 THE WAY HEALTH CARE SERVICES ARE DELIVERED TO THE ABORIGINAL POPULATION

Health and Welfare Canada, through the Medical Service Branch has responsibility for providing health care services to Canada's 350,000 on-reserve Indians and the 7,550 Inuit who live in northern Quebec, Labrador and south of the 60th parallel elsewhere in Canada. The Metis population, some 100,000 obtain health care services (as all other citizens) from the provinces in which they reside.

The Department of Indian and Northern Affairs provides funding for social services for on-reserve Indians including health related services such as homemakers and institutional care, types I and II.

In many cases, services, such as health care, education, housing (etc) are delivered directly by Federal Government departments. However, with the federal government's policy of transferring administration and delivery of services to First Nations and Inuit communities,

at the present time over seventy percent (70%) of the Department of Indian and Northern Affairs, Indian and Inuit Affairs Program budget, for example, is administered by aboriginal communities directly.

Metis people receive services through the provinces in which they reside. Indian and Inuit people who move away from their home communities, receive services through the provinces but costs are the responsibility of the Federal Government through Federal/ Provincial/Territorial Agreements.

The Federal Government, therefore, has a much more significant role in determining the level and quality of health services provided to the majority of the aboriginal population, than for mainstream Canadian society.

However, discrimination and mistrust of the medical system have been cited by aboriginal people as major obstacles to seeking timely health care services if they suspect they may be HIV positive or have been tested positive and require medical care.

The degree to which aboriginal people have access to appropriate HIV testing and the manner in which counselling and treatment are provided, if they suspect they may be infected,depends on where they live and under what jurisdiction health care services are provided.

In addition, the spread of the HIV virus and the potential for a growing number of AIDS cases in the aboriginal population, will have a significant impact on the level of resources transferred from Medical Services, Health and Welfare Canada to Indian and Inuit administrations. The Community Health plans that have been developed in Health and Welfare's Guide on the Transfer of Health Programs, should, therefore, include plans for the education and prevention of the spread of the
HIV virus, testing, counselling, treatment and care of infected individuals.

1.5 THE CHALLENGES IN DEVELOPING THE NATIONAL STRATEGY

The challenge in developing the National Strategy on Aboriginal AIDS Education and Prevention becomes one of recognizing the unique needs of the aboriginal population and determining the most effective ways and means to meet these needs. To simply transfer messages that have been developed for mainstream Canada with their inherent values and mores to aboriginal people would be to simply deny them access to meaningful and vital information.

1.5.1 DENIAL OF AIDS IN THE ABORIGINAL COMMUNITY

According to statistics available from the Federal Centre for AIDS (FCA), resulting from data collected by reporting physicians across the country through the AIDS surveillance process, there have been a total of twenty (20) AIDS cases reported among the aboriginal population as of November 23, 1989.

The following chart compares reported aboriginal AIDS cases with those of other ethnic/racial groups in Canada and notes gender as well as catagories of transmission or risk factors.

AIDS IN CANADA
BY RACE/ETHNIC ORIGIN
GENDER and RISK

November 23, 1989[6]

VARIABLE	ABORIGINAL	CAUCASIAN	BLACK	INDO ASIAN	HISPANIC	ORIENTAL	UNKNOWN	TOTAL	%
I GENDER									
MALE	15	1732	138	17	19	7	1022	2950	(93.7%)
FEMALE	5	91	70	2	0	1	29	198	(6.3%)
II Risk Factors									
ADULTS:									
Homosexual/Bisexual Activities (only)	13	1519	24	11	17	6	914	2504	(79.5%)
Injection Drug User (Only)	1	16	3	0	1	0	8	29	(0.9%)
Both of Above	1	54	2	2	0	0	32	91	(2.9%)
Recipient of Blood Products	2	100	1	2	0	2	50	157	(5.0%)
Heterosexual Activity:									
(a) origin Pattem II Country	0	0	131	0	0	0	4	135	(4.3%)
(b) sexual contact with person at risk	2	64	9	2	0	0	12	89	(2.5%)
No Identified Risk Factors	0	58	6	1	1	0	27	93	(2.9%)
PEDIATRIC:									
Perinatal Transmission	1	6	32	1	0	0	1	41	(1.3%)
Recipient of Blood/Products	0	6	0	0	0	0	3	9	(0.3%)
TOTAL:	20	1823	208	19	19	8	151	3148	(100%)

[6] Bureau of Epidemiology and Surveillance, Federal Centre for AIDS, Health and Welfare Canada, OTTAWA, November 23, 1989.

One of the most serious challenges in developing a national strategy to prevent HIV infection and AIDS in the aboriginal community is denial by many aboriginal people that the virus and the disease exists in the population. Based on reported cases, twenty (20) aboriginal people have AIDS; of these ten have died from the disease. Further, research indicates that for every case of AIDS there are from fifty (50), to one hundred (100) more individuals who are infected with HIV.

In looking at the available statistics, the aboriginal population is ranked as the fourth largest ethnic/racial group out of seven with AIDS in Canada.

1.5.2 THE POTENTIAL FOR HETEROSEXUAL TRANSMISSION OF HIV

The potential for heterosexual transmission in the aboriginal community is another serious challenge in developing an effective prevention and education strategy.

The research indicated that the aboriginal population unlike mainstream Canada shares common characteristics with those infected with HIV in Pattern II countries the most notable one being the high rates of Sexually Transmitted Diseases (STDs). Pattern II countries including those in Africa are defined by the World Health Organization as "those countries with a high rate of HIV infection and where the predominant means of transmission is heterosexual contact."

Because many STDs cause genital ulcerations, the potential for HIV infection among heterosexuals is enhanced. In addition, according to Dr. Jonathan Mann of the World Health Organization, individuals whose immune systems have been activated by chronic infections (such as STDs)

might be more easily infected on exposure to HIV. The STD rates among the aboriginal population are almost four times that of mainstream Canadian society. The potential for aboriginal communities becoming Pattern II communities within a Pattern I country, such as Canada appears to be great.

Based on reported aboriginal AIDS cases twenty-five percent (25%) are female compared to a national average of six point three percent (6.3%). This statistic may also indicate a significant difference in how the virus is spread in aboriginal communities. The size of the sample of aboriginal PWA's is too small to permit statistically significant predictions.

1.5.3 OTHER FACTORS THAT PRESENT CHALLENGES TO THE NATIONAL ABORIGINAL AIDS EDUCATION AND PREVENTION STRATEGY

Because aboriginal communities differ widely from each other, the challenge becomes one of supporting individual community AIDS education and prevention efforts, designed from within to suit particular circumstances.

Because aboriginal communities struggle daily with a number of highly visible social and health problems, the challenge becomes one of stimulating awareness and concern for the very real threat HIV infection poses to aboriginal people wherever they may live.

Because many aboriginal communities have come to believe that they lack the power to change their disadvantaged social, economic and political circumstances, the challenge becomes one of demonstrating to individuals that they do possess the power to change their own behaviors in favour of more positive alternatives.

Finally, the challenge in developing the National Strategy on Aboriginal AIDS Education and Prevention is one of realizing that the issue requires urgent action but respecting the rights of individual communities to determine how and when to act on their own behalf.

2.0 THE PURPOSE OF THE NATIONAL STRATEGY ON ABORIGINAL AIDS EDUCATION AND PREVENTION

The purpose is to guide aboriginal governments, the Federal Centre for AIDS and óthers who may become involved, in determining the most effective measures to take in the battle against AIDS in aboriginal communities.

This strategy is intended to be used by the Federal Government, aboriginal organizations, communities and individuals to decide which activities should be undertaken and where to allocate their resources, time and efforts.

We have written this document in such a way that it will be useful both to policy makers within governments and to communities who are searching for ideas of where to start their efforts.

3.0 GOALS

The Joint National Committee on Aboriginal AIDS Education and Prevention has established the following overall goals for the National Strategy:

(1) to increase general awareness and knowledge about HIV transmission, infection and the development of HIV spectrum diseases and AIDS in the aboriginal population,

(2) to reduce the transmission of the (HIV) virus through education and prevention measures aimed at promoting responsible behaviour such as safe sex practices and safer injection drug practices,

(3) to encourage and support sustained behavior change through community understanding and action,

(4) to encourage individuals who may be at a greater risk of contracting the (HIV) virus to accept personal responsibility for changing unsafe practices,

(5) to assist aboriginal communities to help those who are HIV positive and are expressing HIV spectrum diseases and AIDS, and

(6) to assist aboriginal communities in addressing the social and economic impacts of HIV spectrum diseases and AIDS.

4.0 GUIDING PRINCIPLES

In keeping with the four gifts of the Creator: kindness, honesty, sharing and strength, the Joint National Committee has developed the following guiding principles to assist in the development of aboriginal AIDS education and prevention programs and policies:

(1) The approach must be holistic and rooted in the culture, traditions and customs of aboriginal communities and therefore, must embrace the entire community including the youth, parents, elders and community leaders;

(2) The approach must be positive in nature rather than critical of past behaviors;

(3) The approach must support the empowerment of the community and individuals in their efforts to take responsibility;

(4) The approach must ensure equity of access for all aboriginal communities to information and resources;

(5) The approach must be cognizant and sensitive to differing views of sexuality;

(6) The approach should promote the development of comprehensive efforts against AIDS by communities which includes education and prevention of HIV infection and builds tolerance and understanding of those already infected.

5.0 ELEMENTS OF THE STRATEGY

The National Strategy on Aboriginal AIDS Education and Prevention incorporates five elements to facilitate the attainment of Goals described in 3.0 as follows:

GENERAL AWARENESS AND EDUCATION CAMPAIGNS

(1) General awareness and education campaigns which are aboriginal specific and culturally transportable for broad usage with the support of human and financial resources.

COMMUNITY-BASED INITIATIVES

(2) Specific community-based education and prevention initiatives designed and delivered by local people with the support of appropriate human and financial resources.

AIDS AS A PRIORITY ISSUE

(3) The establishment of AIDS education and prevention measures as priorities within all aboriginal decision-making forums. (for example: First Nations Government Meetings, School Board Meetings, Regional Board Meetings, Tribal activities etc.)

DIRECTED RESEARCH

(4) Directed research which will assist in the development and/or evaluation of future education and prevention efforts and initiatives.

MONITORING THE STRATEGY

(5) Maintenance of the Joint National Committee with a new mandate for a period of three years to ensure that the strategy is marketed, effectively implemented and evaluated.

6.0 PROGRAM GUIDELINES

Aboriginal organizations and community groups have initiated a variety of AIDS education and prevention activities across Canada. As a part of the Joint National Committee's research, those organizations and others were requested to share their ideas on what activities were most effective and had the potential for the greatest impact on aboriginal communities. As a result of their input and additional research, program guidelines have been developed which focus on the five elements of the strategy and the guiding principles on which the strategy is based.

(1) General awareness and education campaigns which are aboriginal - specific and culturally - transportable for broad usage with the support of human and financial resources.

General awareness and education campaigns should be considered by the Federal Government, aboriginal organizations and all other governments within the following parameters:

(a) Holistic -These initiatives should adopt a holistic approach and consider not only those who may become infected with HIV but those within aboriginal communities who will be required to lend support.

(b) Audio-Visual Media -Campaigns should make maximum use of audio-visual media to accommodate varying literacy levels and language differences among aboriginal groups.

(c)	Culturally Transportable	-As much as possible, messages should be adaptable and culturally transport-able to accommodate the information needs of many.
(d)	On-going	-general awareness campaigns should be on-going rather than on a one-time basis.
(e)	Linked With Existing AIDS Activities	-To assist in the development of some of these ideas, linkages should be established with other AIDS groups.

ACTIVITIES MIGHT INCLUDE:

- Theatre productions and other artistic endeavors.
- Social marketing campaigns in the aboriginal media including advertisements, interviews, articles.
- Production of calendars, colouring books and other appropriate materials.
- Regional and National Speaking Campaigns.
- Curriculum packages/FACTS ABOUT HIV & AIDS.
- Education of policy makers on the specific needs of aboriginal people.
- Presentations to: aboriginal governments, aboriginal community organizations such as friendship centres, women's organizations, youth groups, education authorities.
- Presentations to: other governments: municipal, provincial, territorial, federal.

- Presentations to: other agencies such as churches, correctional institutions, other AIDS education and prevention programs.

- Aboriginal participation in international indigenous peoples symposiums and conferences.

(2) Specific community-based education and prevention initiatives designed and delivered by local people with the support of appropriate human and financial resources.

These activities should be developed within the following parameters:

(a) Holistic -These activities should adopt a holistic approach which involves the entire community.

(b) Positive -These activities should adopt a positive approach rather than being critical of past behaviors.

(c) Empowerment -The approach must support the empowerment of the community and individuals in their efforts to take responsibility.

(d) Sensitive -The approach must be cognizant of and sensitive to differing views of sexuality.

(e) Accessible -The approach must ensure equity of access for all aboriginal individuals and communities.

(f) Community-based -These activities should be designed and delivered within the community using the language, customs and traditions.

(g) Integrated -These activities should include HIV and AIDS education with other STD prevention messages.

(h) On-going -These activities should be on an on-going basis rather than one time only.

ACTIVITIES MIGHT INCLUDE:

- Establishing linkages with other AIDS prevention organizations for assistance in program design and delivery.

- Local social marketing efforts based on behavioral change and alternative lifestyles.

- Distribution of condoms and/or easy accessibility in places where people congregate such as, schools, community centres, bingos, socials, pow wows, community events etc.

- Needle exchange programs.

- Establishment of AIDS hotlines for advice and continuous information updates.

- Local aboriginal media public service announcement.

- Development of curriculum packages for in-school use.

- Organizing community workshops and presentations by AIDS experts and/or aboriginal people with AIDS (PWA's).

- Production of local radio/TV shows.

- Production of printed materials, posters and pamphlets.

(3) The establishment of AIDS education and prevention as a priority within all aboriginal decision-making forums, for example: First Nations Government Meetings, School Board Meetings, Regional Board Meetings, Tribal activities. Social Services Agencies, Health Care Committees, etc.

These measures should be considered within the following parameters:

(a)	Facilitative	-Assist and support those who will assume day to day responsibility for AIDS education and prevention measures.
(b)	Long Term, Consistent and Periodic	-Ensure that efforts are planned over the long term with consistent messages and incorporate periodic updates to generate continuous interest.
(c)	Visible	-The aborginal leadership should be seen and heard in their support of on-going efforts in AIDS education and prevention.
(d)	Supported	-The approach must ensure that once AIDS education and prevention has been decided upon as a priority, the necessary support for responsible staff i.e. training and resources are available.

ACTIVITIES MIGHT INCLUDE:

- Discussing AIDS at every scheduled meeting no matter what the purpose or agenda.

- Establishing linkages with other AIDS organizations for information, advice, guidance and training.

- Training programs for existing staff on HIV and other STDs, i.e., CHR's, nurses, interpreters, alcohol and drug abuse counsellors, health committees, etc.

- Presentations to First Nation Governments and other policy makers on community needs vis a vis care for people with AIDS (PWA's).

- Professional and personal support for community workers and all care givers.

- Establishment of a professional network of information and problem sharing.

- Development of resource materials for care givers.

- Planning for the treatment and care of HIV infected employees and individuals.

- Adoption of AIDS related employee policies by the organizations.

- Impact assessment of all efforts which are underway or as they occur to determine the effectiveness of aboriginal AIDS education and prevention activities.

(4) Directed research which will assist in the development and/or evaluation of future education and prevention efforts and initiatives.

These activities should be considered within the following parameters:

(a) Practical -Research activities should result in useful and necessary information.

(b) Generally Accepted Research -Meet the ethical and methodological standards for research generally acceptable Standards within the academic community.

Activities might Include:

- K.A.B. Studies which identify the knowledge, attitudes and behaviors of groups within the aboriginal population for use in future planning and programming efforts.

- Development, adaptation and use of tools designed to measure knowledge, attitude and behavior of the aboriginal population and youth in the areas of sexuality and AIDS.

- Studies to measure knowledge, attitude and behavior of individuals who engage in high risk behaviors.

- Studies that focus on issues which may impact the aboriginal community as a result of AIDS i.e. Economic Impact, Implications For The Transfer Of Health Services.

(5) Maintenance of the Joint National/Committee with a new mandate for a period of three years to ensure that the Strategy is marketed, effectively implemented and evaluated.

The Joint National Committee should:

(a) assist in marketing the National Aboriginal AIDS Strategy through information sharing, identifying specific needs within the constituencies which members represent, following-up on recommendations from other members etc.

(b) review the types of activities undertaken by aboriginal communities, corresponding resource levels, delivery/response time identification of unmet needs, etc. for discussion with the various departments and agencies involved in order to ensure the continued effectiveness of the Strategy.

(c) ensure that an assessment framework is built into every program design which might include:

-pre- and post-test questionnaires

-third party evaluations

-longitudinal studies

-monitoring existing epidemiological data

-serial K.A.B. studies

-formative evaluations

The impact of every aboriginal AIDS education and prevention program should be measured in terms of effectiveness and problem areas identified.

(d) revise, update and add to the strategy when deficiencies are identified.

(e) raise the general awareness about AIDS in the aboriginal community through presentations, workshops, etc.

(f) educate the general Canadian public about AIDS and its potential impact in the aboriginal community and why special measures are required for this segment of the Canadian population.

7.0 GENERAL RECOMMENDATIONS

The Joint National Committee on Aboriginal AIDS Education and Prevention has developed the following general recommendations based on all research and evidence detailed in the Findings Document, (December 14, 1989):

(1) The JNC recommends that based on the unique needs of the aboriginal populations, a specific strategy for Aboriginal AIDS Education and Prevention be developed and implemented by all levels of government.

Rationale: The research clearly indicated that due to the cultural, social, political, geographic and language differences between the aboriginal population and mainstream Canadian society, special measures and a unique strategy are required to meet the needs of aboriginal people in AIDS education and prevention efforts.

In addition, because there is a potential for Pattern II spread in aboriginal communities (heterosexual transmission of HIV), a broader more complex approach is required.

(2) That Aboriginal AIDS Education and Prevention activities, programs and projects be community-based both in terms of design and delivery.

Rationale: Because aboriginal communities are heterogeneous and vary widely from each other in terms of culture, language, geographic location, political structures and demographics, there is not one generic aboriginal approach to designing and delivering the AIDS prevention message. Although it is possible to develop a "culturally transportable" general information message, the greatest community impact will result from careful consideration of what is acceptable to the individual community both in terms of design and delivery. Therefore, priority should be given to community-based groups.

(3) The JNC recommends that available financial resources be allocated to community-based groups who are designing and delivering AIDS education and prevention programs and that information on the availability of these resources be widely publicized and readily accessible.

Rationale: While there are a number of aboriginal AIDS education and prevention programs currently underway across Canada, aboriginal organizations and community groups have cited a lack of financial resources as the major obstacle to developing and delivering effective AIDS prevention programs. Because many of these groups are "overtaxed" in terms of workload and time, there is a need to expand their human resources to address the AIDS issue. In addition, many groups are unaware of the availability of funds, the criteria and time required to process applications and have expressed concern that more information is needed and access should be made streamlined and efficient.

(4) The JNC recommends that aboriginal human resource development to facilitate AIDS activities within aboriginal communities be supported through training and information sharing between communities and other agencies involved in AIDS education and prevention.

Rationale: Although many aboriginal communities have expressed interest in developing and delivering AIDS education and prevention programs, they lack the skilled individuals to carry out the task. They have requested AIDS-specific training for existing social and health care service providers and information (printed resources, videos, etc.) as initial steps in developing their programs.

As a first step, the JNC has recommended that those interested in AIDS and the aboriginal community should acquire as much information as is currently available on the subject so that specific <u>training</u> needs can be identified and addressed within the context of the subject matter.

(5) The JNC recommends that linkages be established between existing AIDS community groups and aboriginal communities to share information, assist with skill development and design effective AIDS education and prevention programs.

Rationale: Non-aboriginal AIDS organizations have provided services to aboriginal people on request however, because the AIDS prevention message would be more effectively delivered by aboriginal people to aboriginal people, their role could be one of training aboriginal resource people. In addition, aboriginal groups require assistance in designing effective AIDS education and prevention programs especially in terms of building in evaluation and monitoring components. Non-aboriginal organizations including universities could assist in the preparation of program proposals.

(6) The JNC recommends that "culturally transportable" or adaptable general awareness messages be developed for use by aboriginal groups across Canada.

Rationale: Due to the lack of basic information on AIDS and its potential impact on aboriginal communities, there is an urgent need for aboriginal-specific information to stimulate awareness and discussion. Aboriginal groups have specifically requested video productions for use in a variety of settings including workshops, aboriginal media productions, classrooms, etc. These messages should focus on the basic facts and present ideas on how individuals and communities can prevent the spread of HIV.

(7) The JNC recommends that AIDS education and prevention efforts also be developed for specific target groups within the aboriginal population who may be at a greater risk of acquiring HIV, for example, aboriginal youth (street youth), injection drug users, male and female prostitutes, the prison population etc.

Rationale: Although it is difficult to target effective messages to individuals who may be at a greater risk of contracting HIV efforts ought to be pursued to depict high risk behaviors and their consequences while at the same time demonstrating realistic alternatives.

(8) The JNC recommends that aboriginal AIDS education and prevention activities designed for the whole community including elders, parents, children, policy makers and service providers be initiated.

Rationale: The research has indicated that without the support of the entire community, sustained behavioral change is not a realistic goal for any AIDS education and prevention measure. All sectors of the community must view HIV infection as a threat and develop the support networks to not only prevent it but, also care for those who have acquired the disease. In addition, our research has indicated that HIV transmission in aboriginal communities closely mirrors that of Pattern II countries. While Canada is viewed as a Pattern I country because HIV transmission has been linked largely to homosexual/ bisexual activity and injection drug use, the Committee fears that aboriginal communities, due to high STD rates, may experience HIV infection through heterosexual activity at greater rates than the general population. It is critical therefore, that the aboriginal community as a whole be involved in AIDS education and prevention and be made aware that the threat of HIV transmission is not limited to homosexual/bisexual or injection drug use activities.

(9) The JNC recommends that HIV seroprevalence studies be undertaken within aboriginal communities but, that these studies be contingent on the approval of the community and fulfill the conditions set out by Somerville and Gilmore in 1988, in their paper on HIV Antibody Testing in Canada as follows:

1. Ethically justified studies should only be conducted in a blinded (unlinked) anonymous fashion;

2. Ethically justified studies should only be done on specimens which have been obtained for other routine tests;

3. Only demographic information already attached to such specimens should be collected;

4. Voluntary HIV antibody testing under the conditions of informed consent, pre-/post-test counselling, and confidentiality must be accessible to persons who are being seen in the proposed study setting.

Rationale: Existing seroprevalence data and demographic information is incomplete and lacking in aboriginal communities. This information is essential for: monitoring the spread of the disease, program planning, resource allocation and program evaluation.

(10) The JNC recommends that access to confidential and free HIV testing be made available to all aboriginal people across Canada.

Rationale: An individual's knowledge of whether or not he/she is HIV positive is a step in preventing the further spread of the virus. It is important for those aboriginal people who may wish to be tested, that access to this service is readily available.

In addition, individuals who are aware of their status may wish to seek timely intervention of the disease through the use of drugs such as AZT which may delay the expression of HIV spectrum diseases and AIDS.

(11) The JNC recommends that obstacles posed by the health care system to aboriginal people which delay the timely intervention of measures to minimize the expression of HIV spectrum diseases be specifically identified and steps be taken to remove them.

Rationale: Discrimination and mistrust of the medical system have been cited by aboriginal people as major obstacles to seeking timely health care services if they suspect they may be HIV positive or have been tested positive and require medical care. Notwithstanding the commitment of some Medical Services personnel who provide health care and advice to Indians and Inuit living in remote, isolated and rural communities, some aboriginal people have expressed reluctance to share "personal" information with them for fear of a "judgmental" response. Cultural sensitivity training has been recommended for existing medical staff. More documentation on this phenomenon is also required.

(12) The JNC recommends that condoms and needle exchange programs be readily available and easily accessible to aboriginal people.

Rationale: It is essential that preventive measures such as practicing safe sex and safer drug injection practices be supported by the ready availability of condoms and needle exchange programs. Without the appropriate support, preventive messages will go unheeded.

(13) The JNC recommends that where appropriate and financially feasible that KAB (knowledge, attitude, and behavior) studies be undertaken to facilitate planning, designing, implementation and as a means of evaluating the effectiveness of AIDS education and prevention programs.

Rationale: Although KAB studies should not be prerequisite to the development and delivery of effective aboriginal AIDS education and prevention programs, they are however important tools in evaluating effectiveness in terms of behavioral change and provide specific information to facilitate planning.

(14) The JNC recommends that quality research efforts be supported which examine the sexuality and the sexual behaviors of aboriginal people.

Rationale: There are few historical or anthropological accounts of how aboriginal people viewed sexuality and how the arrival of missionaries, tradespeople and others altered these views through the imposition of foreign value systems.

While current statistics are available to indicate the high rates of; STDs, sexual abuse and teenage pregnancies among the aboriginal population, no research has examined the impact of factors that have resulted in these circumstances.

A thorough understanding of the traditional sexuality of aboriginal people and sexual behaviors today may result in culturally-motivated behavior change.

In addition, denial of homosexual/bisexual behaviours may be replaced by a greater understanding of the facts.

(15) The JNC recommends that research efforts be supported to examine the role of traditional medicine and healing in AIDS.

Rationale: Little is known about the impact of traditional medicine and healing on AIDS but, there is reason to believe that the holistic nature of traditional medicine may be beneficial for an HIV infected person. Traditional healers were among one of the first groups to emerge from the aboriginal population as concerned and eager to assist in AIDS intervention. Because there have been claims that traditional medicine has successfully delayed the progress of HIV spectrum diseases and AIDS, there is a need to investigate these claims and document the results.

(16) The JNC recommends that research efforts be supported to examine the economic impact of AIDS on the aboriginal community.

Rationale: Because AIDS has the greatest impact on the 25-39 year-old age group, the economic impact of AIDS in a small community could be devastating. In Africa, where large populations have contracted AIDS, the economic impact in an already unstable economy has been disastrous. It is essential that this aspect of the disease be examined, so that intervention measures can be projected and planned.

The costs of caring for aboriginal people with AIDS in the community should also be examined.

(17) The JNC recommends that quality research efforts be supported to examine the implications of AIDS on the Health Transfer from the Federal Government to First Nations governments.

Rationale: The implications of the policy of the Federal Government to transfer responsibility for Medical Services to First Nations governments must be critically examined in terms of <u>future</u> resource needs.

Current transfer funding formulae do not consider the costs associated with medical services for people with AIDS nor do they cover the costs of mental health needs associated with AIDS.

Policy and financial issues must be examined in detail to accurately assess the transfer implications.

(18) The JNC recommends that the involvement of Canada's aboriginal people in an international conference of indigenous people and AIDS be financially supported by the Federal Government.

Rationale: Because aboriginal people in Canada share common concerns and problems vis-a-vis HIV infection and AIDS with indigenous peoples in North, Central and South America, Australia and New Zealand, it is important that information be shared among these groups.

Both the National Association of Friendship Centres and the Native Women's Association of Canada made this recommendation by resolution generated at their annual assemblies held in 1989.

(19) The JNC recommends that a mechanism be implemented to facilitate the on-going involvement of aboriginal people in monitoring the effectiveness of the National AIDS Strategy which will include the Aboriginal AIDS Education and Prevention Strategy.

Rationale: While the Joint National Committee has invested a great deal of work and careful consideration in the development of the National Strategy, it is essential that where new initiatives

emerge or certain aspects of the Strategy are not implemented, that a body comprised of representatives of the aboriginal population and the federal government be mandated to revise, update and reconsider the Strategy based on the urgent needs of the aboriginal community.

8.0 ROLES AND RESPONSIBILITIES

The Joint National Committee has identified the roles and described the responsibilities of all those who should be involved in aboriginal AIDS education and prevention including, individuals, aboriginal communities, aboriginal governments, aboriginal organizations and institutions, the federal government and provincial and territorial governments. It is anticipated that the roles and responsibilities of key participants in aboriginal AIDS education and prevention will become more clearly defined as the strategy is implemented and evaluated.

8.1 THE INDIVIDUAL

(a) It is the responsibility of every individual to ensure that his/her behaviour does not contribute to the spread of HIV by:

-educating themselves about the risks so that informed choices are possible;

-seeking advice/assistance when in doubt;

-seeking testing where appropriate;

-practicing safe sex through the use of a condom;

-avoiding multiple partners;

-avoiding injection drug use or by using clean needles.

(b) It is the responsibility of every individual to share knowledge and information with others by:

-speaking in an open and caring manner about HIV with children, family and friends

-offering appropriate advice, encouragement and support to those who are at risk or who may be infected with HIV.

8.2 **ABORIGINAL COMMUNITIES**:

(a) It is the responsibility of aboriginal communities to initiate AIDS education and prevention activities by:

-displaying AIDS education and prevention messages;

-requesting and/or organizing condom distribution in the schools and where people congregate;

-participating in local workshops/radio shows;

-requesting more information in the appropriate language;

-requesting ready access to HIV testing and counselling.

(b) It is the responsibility of aboriginal communities to create a tolerant and supportive environment for those infected with the HIV by:

-changing attitudes through greater knowledge and understanding;

-welcoming those who are infected home;

-insisting on appropriate health care (physical & mental) in the community for those infected with HIV.

8.3 ABORIGINAL GOVERNMENTS:

(a) It is the responsibility of aboriginal governments and decision-making bodies to make AIDS education and prevention efforts a priority by:

-identifying and responding appropriately to community information needs;

-encouraging multi-sector involvement in education and prevention efforts;

-addressing AIDS and related issues on an on-going basis at all public forums;

-supporting the efforts of those concerned with HIV and AIDS programming through training and allocation of resources;

-establishing linkages with other groups concerned with AIDS to seek additional information and support for activities;

-developing and implementing supportive personnel policies for those who are or may become infected with HIV.

(b) It is the responsibility of aboriginal governments and decision-making bodies to create and maintain tolerant and caring environments for those who are infected with HIV by:

-demonstrating exemplary behaviour through the implementation of supportive personnel policies

-ensuring that appropriate resources are available to support and care for those who are infected.

8.4 ABORIGINAL ORGANIZATIONS AND INSTITUTIONS:

(a) It is the responsibility of aboriginal organizations and institutions to ensure that the people they represent and serve are aware of the very real threat HIV poses to aboriginal people by:

-organizing presentations to assemblies, staff, etc;

-participating in workshops and public forums;

-updating and sharing available information and statistics at all meetings regardless of the agenda.;

-ensuring that the necessary research is supported and resulting information is shared and acted upon.

(b) It is the responsibility of aboriginal organizations and institutions to ensure that the people they represent and serve are supported in their efforts to implement AIDS education and prevention programs by:

-participating on the Joint National Committee;

-lobbying for needed resources;

-sharing information and methodologies;

-developing training programs for staff;

-establishing linkages with others involved in AIDS.

(c) It is the responsibility of aboriginal organizations and institutions to ensure that the people they represent and serve are supported in terms of providing care for those infected with HIV by:

-participating on the Joint National Committee;

-identifying health care issues and needs (Health Care Transfer);

-lobbying for needed resources.

8.5 THE FEDERAL GOVERNMENT

(a) It is the responsibility of the Federal Centre for AIDS, Health and Welfare Canada to market, implement and evaluate the National Aboriginal AIDS Education and Prevention Strategy.

(b) It is the responsibility of Health and Welfare Canada and the Department of Indian and Northern Affairs to collaborate with aboriginal organizations on the Joint National Committee for a three year period and to support the efforts of the JNC by:

-financing the involvement of aboriginal representatives on the committee;

-supporting presentations by the JNC to the aboriginal community and others;

-supporting information sharing mechanisms.

(c) It is the responsibility of the Federal Government to co-ordinate and deliver resources to support aboriginal AIDS education and prevention measures through:

-Health and Welfare Canada (FCA) widely publicizing the availability of resources, explaining criteria and facilitating the timely release of funds.

-Health and Welfare Canada (FCA) co-ordinating necessary resources with provinces and territories.

-Department of Indian and Northern Affairs providing the necessary resources to support AIDS curriculum development for in-school use.

(d) It is the responsibility of Health & Welfare Canada to deliver effective and culturally-sensitive aboriginal AIDS education and prevention programs in aboriginal communities by:

-training Medical Services personnel and following-up on results in the community

-training and resourcing aboriginal AIDS workers.

(e) It is the responsibility of the Federal Centre for AIDS to ensure that aboriginal AIDS research projects, resourced by the FCA, result in practical information and useful data through:

-establishing review committees to evaluate research proposals.

(f) It is the responsibility of the Federal Centre for AIDS to assist aboriginal communities, governments, and organizations in the design, delivery and evaluation of AIDS education and prevention projects by:

-facilitating linkages with appropriate sources of expertise including universities, health care professions and others.

(g) It is the responsibility of the Federal Centre for AIDS to ensure that aboriginal-specific AIDS issues are discussed and considered by the Federal/Provincial/ Territorial advisory group on an on-going basis.

(h) It is the responsibility of the Federal Centre for AIDS to demonstrate its commitment to preventing HIV in the indigenous cultures of Canada by facilitating discussions and information-sharing with other indigenous cultures from the U.S., Mexico, Australia and New Zealand through:

-hosting the First International Indigenous Peoples Conference on AIDS and sponsoring Canada's lead role through the National Association of Friendship Centres.

8.6 PROVINCIAL AND TERRITORIAL GOVERNMENTS

(a) It is the responsibility of Provincial and Territorial governments to co-ordinate and deliver resources to support aboriginal AIDS education and prevention programs/ activities especially in urban areas.

(b) It is the responsibility of Provincial and Territorial governments to assist aboriginal communities in the design, delivery and evaluation of aboriginal AIDS education and prevention programs by facilitating the establishment of linkages with sources of expertise including universities, health care professions, etc.

(c) It is the responsibility of Provincial and Territorial governments to participate in on-going discussions with aboriginal groups concerned with AIDS in their provinces and territories and to ensure that their specific concerns are discussed by the Federal/Provincial/Territorial advisory groups.

9.0 CONCLUSION:

Over the past nine months, the Joint National Committee has examined the threat of HIV and AIDS to aboriginal communities from an aboriginal perspective. While there was little accurate or current information to begin or guide the process of developing an aboriginal-specific AIDS education and prevention strategy, a great deal has been learned since April, 1989.

Recommendations resulting from the JNC's research and knowledge are provided as first steps in addressing the many various and urgent AIDS education and prevention needs of the aboriginal population.

It will require the involvement of many committed individuals and organizations to collectively battle the threat of AIDS in our communities. Elders, traditional healers, parents, youth, educators, health care providers, politicians, policy makers, all levels of government and concerned individuals have key roles to play in preventing the spread of HIV and in supporting those who are already infected with the virus.

A holistic approach involving all sectors of the community will encourage support for sustained behavioural change for those endangering themselves and others through participation in high risk activities. Research efforts will attempt to identify and describe why our communities are at a greater risk of contracting the disease than others in Canadian society and will assist in designing realistic interventions.

It is up to aboriginal communities to make AIDS education and prevention a priority. Through swift, determined, collaborative and co-operative action, we may, as a people, overcome another assault on our well-being and threat to our growth and survival.